WORKERS' COMPENSATION INDUSTRIAL COUNCIL

APRIL 29, 2010

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, April 29, 2010, at 3:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

Industrial Council Members Present:

Bill Dean, Chairman
Kent Hartsog, Vice-Chairman
Bill Chambers
James Dissen
Dan Marshall
Delegate Nancy Guthrie

1. Call to Order

Chairman Bill Dean called the meeting to order at 3:05 p.m.

2. Approval of Minutes

Chairman Bill Dean: The minutes were distributed from the last meeting. Is there a motion to approve the minutes as stated?

Mr. Dissen noted that Vice-Chairman should be placed after Mr. Hartsog's name instead of his name [on the first page of the March 25, 2010 minutes]. That correction was made.

Dan Marshall made the motion to approve the minutes from the March 25, 2010, meeting. After the correction was made, the motion was seconded by James Dissen and passed unanimously.

3. Office of Judges Report – Rebecca Roush, Chief Administrative Law Judge

Judge Rebecca Roush: Good afternoon, Mr. Chairman and members of the Council. I would like to welcome Mr. Chambers to the Industrial Council. My name is Rebecca Roush and I am the Chief Administrative Law Judge at the Office of Judges.

The Office of Judges is the first level of workers' compensation appeals in the workers' compensation system. Further appeals can be made to the Board of Review and then to the West Virginia Supreme Court. We regularly provide the Industrial Council with a monthly report on the statistics of the work being performed in our office, and that's what we generally go over. The report includes some basic statistical information, including the number of protests we acknowledge, the number of issues we resolve, and our performance measures with regard to the compliance requirements found in 93CSR2.

For my report today, I would like to do something a little different [PowerPoint presentation]. Last month Mr. Hartsog asked me to provide the Council with some detailed statistics on the medical litigation we have in our office, and that's what I have for you today. But first I want to go over the numbers for March.

We acknowledged 495 protests in the month of March, making that a total of almost 1,300 protests received year-to-date for all of 2010. We resolved 519 issues, which means that we're still resolving more than we're taking in. But as you will see in the statistics and graphs, it looks like we are plateauing a little bit. We are averaging around 3,800 to 4,100 protests at any given time. Our pending caseload for the month of March is 3,839 protests.

This is how it breaks down with regard to the types of litigation that we have in our office. Our top three issues that we see in litigation are permanent partial disability, followed by compensability, followed by medical treatment.

Bill Chambers: Rebecca, in terms of the pending caseload and the difference between protests acknowledged, do you have a goal of where you want to get your caseload to?

Judge Roush: In the past, of course, there was a high volume of litigation. We don't have any issues with regard to managing the current caseload that we have. But we're still producing quite a bit so I don't see any issues with regard to meeting a goal for processing the protests. Is that fair, Judge Drescher?

Judge Alan Drescher: The only thing to remember is we don't have any control over the number of protests that comes in. It's the function of how many decisions are issued by the claims adjusters and how many are protested.

Mr. Chambers: I was just curious that 3,800 pending cases you feel is an acceptable level.

Judge Roush: Yes, it is an acceptable level. Our office has decreased in size over the years. We'll show some litigation statistics. But at our peak we had around 30,000 protests in litigation in our office at any given time. Since the reform of the Legislative amendments in 2003, 2005, 2007, and all the years subsequent, litigation has decreased very significantly. And of course our office has also downsized through the course of attrition. So what was a 150 employee operation is now a 60 employee operation. We've got a manageable caseload for the number of people that we have.

Mr. Chambers: Thank you.

Judge Roush: Again, Mr. Hartsog asked me to provide some statistical information on medical treatment and I wanted to give a basic overview. W. Va. Code §23-4-1 is the statutory authority for eligibility for medical benefits. A claims administrator must provide medically related and reasonably required medical treatment, health care or health goods services pursuant to statute for any injury received during the course of and as the result of an employee's employment. And of course §23-4-1(a)(1) sets out that a claimant can obtain health care services, durable medical goods and other supplies as may be reasonably required. That's the basic framework for medical treatment in West Virginia.

Then we have Rule 20, which is probably at the heart of the medical treatment debate, and that is the Medical Management of Claims Regulation. As you all know, Rule 20 is a treatment guideline. Those provisions of the rule are not intended to dictate results, and there are circumstances that can exceed the rule. However, the rule does provide that treatment outlined in the rule is presumed to be medically reasonable and treatments in excess of those are presumed to be medically unreasonable. Of course a regulation cannot exceed statutory authority, but medical necessity is the basic framework for a claimant receiving treatment or medical benefits.

Treatment outside of Rule 20 – A claimant can receive treatment outside of Rule 20 if a preponderance of the evidence is presented to establish that the treatments in excess of those are medically reasonable. Again, the basic framework for eligibility is medical necessity for the treatment.

This, Mr. Chambers, is a graph that outlines this deep decline in litigation that we had since the reform [starting in 2003], and we've included this just to 2009 because we're still into starting 2010. I should say, as a disclaimer, I'm not a mathematician or a

statistician, but these numbers just reflect the litigation universe. They're not really reflective of anything other than what we receive in our office. The cause of the decline or any conclusion you reach as to why the litigation has declined is open for interpretation. These are the total of protests acknowledged by carrier. So we've divided down to include the Old Fund, private carriers and self-insured employers.

Mr. Chambers: Do you have the ability to break that further down by specific private carrier for example?

Judge Roush: Yes, we would have that. We could make that available to you. With regard to the percentage of litigation by carrier, this chart breaks that down further. It is calculated by the total protests divided by the total protests received by carrier. For 2009, of all litigation in our office the Old Fund had 24%; private carriers made up 50%; and self-insured employers made up 26% of all litigation we had in our office. So that's a little background giving you some information on the treatment protests that are pending, and this is how that graph looks. Again, we've seen a steady decline.

In 2009 we had 1,300 treatment protests in litigation at the Office of Judges. And this is how it breaks down by private carrier, self-insured employer and the Old Fund. In 2009 there were 1,300 total treatment protests; self-insured employers made up 37% of that; private carriers 25%; and the Old Fund 38%. And you can see on this graph that the Old Fund has just steadily declined with regard to the percentage of treatment. There is a variance with regard to private carriers and the self-insured employer. While the total number of protests have not varied that much, the overall percentage has increased.

I wanted to tell you a little about how these issues have been resolved. I find these statistics to be very interesting. How did we decide the cases in our office? There are a number of categories. Of course everyone understands "reversed" and "affirmed." Then we have "affirmed by rule," which basically is a Failure to Prosecute Rule that we have in our Procedural Rule in 93CSR1. If the protesting party fails to submit any evidence or argument in support of their litigation, then the Order is automatically affirmed by rule. Of course then you could have "dismissed." Those are protests that could be withdrawn – settlements, things of that nature. "Modified," technically means that the original Order was modified in some fashion. For instance, the date of last exposure or the date of injury could have been modified by the administrative law judge, something of that nature. "Moot" actually corrects the original Order. It makes it "not of particular significance," and more or less means that it makes the litigation of that Order unnecessary. "Other" is anything that does not fall into that category; things such as affirmed in part, reversed in part, remands – those all fall into the other category. This is

our resolution data for all of 2009. This is all issues – it's not just medical treatment alone. It has all been combined – 5,606 issues; 24% were reversed. So that means the remainder – with the exception of "modified, moot and other," which makes up about 6%; 70% of the original Orders in litigation were affirmed, and that's for all protests.

James Dissen: Judge Roush, if 24% is reversed, is that standard or uncommon?

Judge Roush: That's a good question because I think you'll see as we go through the remainder of the presentation that is consistently the number – right about 24%, 25% – regardless of the issue, regardless of the carrier. So I think that shows some uniformity on our part. I wouldn't want to speculate as to whether the number was significant or insignificant. But more or less, a great number of Orders that come to our office are affirmed.

Resolution of Treatment Issues – This is the entire total for calendar year 2009. Again, we only reversed 25%. For the Old Fund, there 569 treatment issues; 24% were reversed. For private carriers, the number is substantially similar. There were 408 treatment issues in litigation; 23% were affirmed. For self-insured employers there were 435 issues resolved; and 24% were reversed.

Kent Hartsog: That is amazingly consistent.

Judge Roush: Yes, it is amazingly consistent. We were all surprised by the number as well. There was not a lot of variance with regard to the resolution of the issues. That's basically my short presentation on medical treatment issues. Are there any questions?

Chairman Dean: Mr. Marshall?

Dan Marshall: No, Mr. Chairman. Thank you for your presentation.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: Very good and very timely.

Chairman Dean: Mr. Dissen?

Mr. Dissen: Very good report. Thank you.

Chairman Dean: Mr. Chambers, do you have any questions?

Mr. Chambers. No more questions. Thank you.

Chairman Dean: Delegate Guthrie, do you have any questions?

Delegate Nancy Guthrie: None. Thank you.

4. Approval to Final File Rule 8 and Rule 22

Title 85, Series 8 (Amendment)
"Workers' Compensation Policies, Coverage Issues and Related Topics"

Title 85, Series 22, "Medical Review"

Mary Jane Pickens (General Counsel, OIC): Before we go into the discussion on that, it is the Insurance Commissioner's suggestion that action on both of those rules be deferred until the June 3 meeting. The situation with Rule 8. . .I wasn't at the last meeting, but my understanding is Mr. Hartsog wanted to make sure that we had some information back from certain state agencies that perhaps had worked with us closely and relied upon – this is the exemption letter process – the rule that would strike that. We haven't gotten all of those letters back. We have received a statement back from the state police to the effect that they actually incorporated – Ryan correct me if I'm wrong – incorporated this process into a rule that they have for inspection stations to inspect cars.

Ryan Sims (Associate Counsel, OIC): That is an internal rule they have.

Ms. Pickens: Correct. I've met with the Municipal League because we were concerned about cities adopting some aspect of that exemption letter process or relying on it in some fashion. We really want to make sure that we have an opportunity among ourselves to consider how we need to approach that issue. We recognize there are some business purposes for the process. The reliance on the regulator – understandable reliance on the regulator – to make that determination of whether someone should have workers' compensation coverage or not under the law, we want to make sure that we've adequately considered all of that. We would request that action on Rule 8 be deferred until June 3, and we could come back with further suggestions then. And just to let you know, it may be that we look at another rule, which is Rule 32. This is the rule that addresses other state agencies working with us on employer enforcement issues. At this point we would probably suggest we continue with what the

proposal is to Rule 8 – striking the language in Rule 8. But it might be appropriate to preserve the concept, and the logical place to preserve it would be in Rule 32. So, we just need to get our ducks in a row on that, and we would appreciate it if we had another month to do that.

Chairman Dean: Very good. No action will be taken on either rule today – Rule 8 and Rule 22. But I would like to go ahead and let Ryan and Dan explain their part, and if the Industrial Council has any questions, I'd like for you to ask them today. Ryan, would like to do Title 85, Series 8 amendment?

Ms. Pickens: Oh, I'm sorry, and I should have said this earlier. We only received one comment on Rule 8, and it is consistent with the concerns that we have. We only had the one comment, and we do not have any formal written responses at this time.

Chairman Dean: Very well. We'll go onto Title 85, Series 22, Medical Review.

Dan Murdock (Associate Counsel, OIC): For those of you who don't know me, my name is Dan Murdock, and I'm Associate Counsel here at the Offices of the Insurance Commissioner. On Rule 22, we received some very substantive comments, and after reviewing those – a lot of which we felt were very good comments – we went through and made some revisions to the rule. And I think that we were successful in incorporating a lot of the suggestions that we received. So I think the easiest way for me to do this is to just go through the sections of the rule in the order where we made some revisions.

In the "Definitions" section, we had a lot of comments on the definition of "medical review." The term "medical review," as defined, meant the "clinical review" of the file. There was some question as to what the scope of that review would be. So, in response to that comment we've defined "clinical review." It is essentially a review of the claimant's claim file – the medical documentation that the insurer has; a review of that information by a physician to make a determination on the medical treatment at issue. The "medical review" definition itself contained a provision that the review would have to be conducted by a physician licensed in the State of West Virginia. We received a lot of commentary on that. Our concern when we put that in there was that the review be done by a qualified physician. There was no desire I don't think to limit that geographically. That's the way it was phrased. We've taken that out. "Medical review" as defined now would only require that the review is conducted by a physician licensed in the United States and that that physician is familiar with West Virginia's workers' compensation laws. So that physician would have to have some familiarity with Rule 20 before they could conduct that review.

Additionally, we added two definitions. One of them was for a "prescription request," and one of them was for a "treatment request." We did that because – I'll go through the sections later – but there were some areas where we felt, in response to comments, that certain provisions of the rule encompassed more than they should encompass. So we wanted to be able to make sure that those later sections addressed issues as specifically as possible.

The definition of "prescription request" is any written communication received by the responsible party requesting authorization or payment for a prescription medication. Prescription requests are generally handled differently than say a request for surgery. Prescription requests can come in the form of a prescription slip. They can come in the form of ongoing billing if the claimant has been on a medication for a certain period of time. They are handled differently than requests for a specific medical treatment. We wanted to differentiate that from a "treatment request," which is a request for medical treatment or durable medical equipment made by the claimant's authorized treating physician or authorized consulting physician on a form promulgated by the Insurance Commissioner. We have received a number of comments asking what would constitute a "treatment request." Is it a telephone call from the claimant's physician? Is it a letter from the claimant's lawyer? We wanted to limit that specifically so that a carrier, in trying to follow the provisions of this rule, would know exactly when a treatment request was filed because it would be filed on a form that we would implement for that purpose.

Section 85-22-3 – Medical Review Required. We did a little cleanup. There were comments regarding general clarity of the language, so we did some cleanup language. In subsection 3.1.d., which is now 3.1.c., we tried to clarify that language to make sure that it was clear, that that section of the rule would only apply if you had a compensability decision based on a medical determination. If you're looking at the compensability of a claim and you have a claimant who may have been hurt at work; your investigation reveals that he was actually injured while he was hunting, that is not a medical determination. But if you're challenging whether the mechanism of injury could cause a certain condition, something like that, that's a medical determination and that's what would be included under the provisions of the rule.

We tried to clarify what "prescription requests" would be covered by the rule. With all of these provisions we wanted to limit the rule to situations where the issue being determined was a significant one in terms of the claimant's ability to recover from his injury, return to work, things of that nature. Surgery is obviously a major issue. With regard to "prescription requests," we wanted to limit that essentially to drugs that the claimant was taking around the time he's found to reach maximum medical

improvement. Our thinking is if he's found to be at maximum medical improvement while he is taking that medication, then that medication could very well be contributing to the fact that he's at MMI. So we wanted to do that, but we wanted to limit it to drugs – in response to comments again – that the claimant had been taking for a significant amount of time. If he was taking a drug for a month, it's sort of a transitory medication that he's taking. We didn't want to include that. We just wanted to include essentially maintenance drugs that the claimant had been taking for a substantial amount of time. We revised 3.1.d to require that the claimant be taking the drug for a continuous period of at least 90 days, and that the claimant be taking it within 90 days of the date that he is first found to reach maximum medical improvement.

To address some other stylistic changes in the language, the original draft of the rule talked about the physician authorizing the denial. And the physician is not really authorizing the denial. The carrier is authorizing the denial. The carrier is making that decision. So we changed the language to indicate that the decision is being based on the opinion of the physician.

Section 85-22-4 – Requests Deemed Approved. We had a large number of comments on that suggesting that we make that time period "15 working days" to coincide with the "15 working days" authorized under Rule 1 for the carrier to take action on a request for medical treatment. We made that change. And we also clarified the issue of what kind of a written response the rule required. The rule doesn't require a decision on the issue. All the rule requires is that the carrier acknowledge in writing the treatment request. You'll see that language, "acknowledge in writing any treatment request." We wanted to clarify that a prescription request, because they are so frequent and handled much differently, they would not be included in the provisions of that section. And compensability rulings would not be included in the provisions of that. Under this section, if the acknowledgement is not made, the treatment is deemed approved. If a claimant is waiting for treatment – medical treatment that his physician is saying that he needs – his physician has filled out that form, it's reasonable then to go ahead and deem that treatment to be approved. But in an issue, say a compensability of a claim, it would not be reasonable to force the carrier to accept compensability over the entire injury.

Subsection 4.1 has been limited to just apply to "treatment requests" on that form prescribed by the Commissioner. And subsection 4.2, "failure to state the name of a physician who authorized the denial." We've taken that section out. There was some commentary that due to a mistake. . .say the claimant or the carrier listed the wrong physician, would that require the treatment to be denied? We felt that because the rule

requires that the physician be named, we didn't need that section and this clarified that. So we've taken that out.

Section §85-22-5 – Exceptions. There were, again, a number of comments regarding treatment that's requested that is obviously unrelated to the compensable injury. The claimant has a broken ankle and is requesting a cervical collar. We wanted to exclude those types of situations from the provision of the rule.

Subsection 5.1.a. "Any treatment request or prescription request relating to the treatment of any physical or mental condition affecting a body part or body system for which no diagnosis has been recognized in the claim." If the claimant has a shoulder injury and he is requesting something for his foot, that would fall within that exception. You wouldn't have to go and have a review of the file for that. Say he's [claimant] got a knee sprain. He goes to his doctor and his doctor says, "I think you've got a torn meniscus." That torn meniscus is not a compensable part of the claim. If the doctor says, "We're going need to perform surgery to correct that," then it's obviously not a different body part. It's the same body part. And in a situation like that, the rule would require a medical review.

And the second exception is "any request that is identical to a prior request denied in accordance with the provisions of this rule." If a request comes in and it falls within the limited scope of this rule, you need to go through this process. You would only have to do it once. If a month later the claimant's physician – without providing you with any additional information – re-submits the same request, you wouldn't be required to have that request go through this process.

We also received some general comments indicating that this rule may conflict with other rules that are already in effect [or other statutes], mainly Rule 20 and W. Va. Code §§ 23-4-1 and 3. I've addressed those comments in the written response. The main thing I would point out with conflict with Rule 20 is that Rule 20 does set forth guidelines, but those guidelines shouldn't be used as bright-line determinators to terminate treatment or deny treatment. The claimant is still [under the statute] entitled to any treatment that is medically necessary or reasonably required to treat his compensable injury. If you have a claimant, again in the limited circumstances where this rule would apply that's requesting surgery, the denial under Rule 20 still requires that adjuster to make essentially a medical determination. And we feel that that medical determination should be made by a physician rather than a property and casualty adjuster.

We also received comments regarding other safeguards and avenues of redress that are available to a claimant when treatment is denied. Obviously a claimant can go and litigate his claim. A claimant can file a consumer complaint. If a claim is unreasonably denied, the claimant is entitled – following the completion of litigation – to petition the Office of Judges for attorney's fees, if the Office of Judges finds that the denial was "unreasonable."

Again, I discussed these all in the written comments. But to briefly address those issues, it's our opinion that all of these remedies are either untimely for a claimant who is waiting for medical treatment that may or may not actually be appropriate, and that it makes more sense to address these issues at the beginning with a proper review of the medical treatment request rather than waiting for the issue to go through litigation. That's a general overview of the rule as it stands now. Do you have any questions?

Chairman Dean: Mr. Marshall, do you have any questions?

Mr. Marshall: No, I don't. I want to thank Dan for a very thorough job with his attention to the comments, and revision of the rule, and with respect to the comments.

Chairman Dean: Mr. Hartsog, do you have any questions?

Mr. Hartsog: Just a couple. Has it been looked at with regard to what the cost of this rule is to the Old Fund, to businesses, to the state municipalities?

Mr. Murdock: In terms of the Old Fund, this is essentially a process that we already use. As a general practice, any significant medical requests that come in are looked at by a physician, if it's an Old Fund claim. In terms of the costs in general – either to the business community or to state and municipal employers – we have not received a final analysis of that yet. That is something we're working with NCCI to obtain, and we've been in conversations with them and they're looking at this. That was one of the reasons we wanted to give this a little more time, to get that information so you would have it. As a general observation around the country – and again we're trying to get exact statistics on this to do a survey state by state – this is not an uncommon rule. We feel very confident now that the information we have is a majority of jurisdictions have some sort of medical review process, and it's kind of a "best practice." We don't know the specific information on what the expected cost would be. If you don't comply with the regulation and you don't get your acknowledgement out and you have to pay for a prescription because you haven't done that – or I guess in this case it would just be a treatment request – if you have to pay for arthroscopic knee surgery because the request wasn't acknowledged, that's going to be a cost. That cost

could be avoided by complying with the rule. The short answer is we don't have a final number or a final projection of what we feel the cost would be. We are hoping to get that information and information on other jurisdictions.

Mr. Hartsog: What is exactly the problem you're trying to address by this rule? Is it just to put a process in place that you feel more mirrors what other states are doing and that you're trying to get more information on that? Or is there a real problem with regard to medical denials, or whatever that is out there that you're trying to get?

Mr. Murdock: We know that there are claimants who have significant medical treatment requests denied by an adjuster that are later reversed at the Office of Judges. We have complaints that come into our office. That's another area where we're hoping to be able to give you a quantifiable number in terms of the complaints we get – what percentage would be affected by this rule; or maybe a remedy would have been available under this rule. We know that it happens. We can't put an exact number on it at this point. And it's something that's very hard to quantify in a way. You can look at litigation statistics and you can look at consumer complaints that we receive. But there is no way to know how many claimants are there that get denied. They argue with the adjuster for a couple of months and then they give up because the adjuster says, "We're not going to provide this treatment or this medication." You're never going to have a completely accurate number, but I think we can certainly provide you with statistics from the complaints that we do receive. Of course we have some information that we've received from the Office of Judges as well.

Mr. Hartsog: That kind of leads me to my next question. In the information we saw here just a few minutes ago, there's about 25% of the medical claims that are petitioned to the Office of Judges that are reversed, in essence. Is there a way to look at that and see if it's a particular insurance company, TPA, or whatever the organization is that is disallowing them, and then the Insurance Commissioner address them directly and solve the problem like that? My concern here is that a rule, in sending out a piece of paper just acknowledging it and perhaps having a medical review, a doctor review, may be better. It could be worse, but could better in having a doctor look at it. It may not solve what you're trying to get at. Has the OIC looked at dissecting that 25% and seeing if there's a common thread or insurance company or provider that needs to be looked at and addressed directly instead of trying to address the whole population of insurance companies and everyone else out there and increase their administrative work?

Mr. Murdock: I think it would be a pretty substantial task. The only way to do it would really be to pull all of those decisions and have someone go through them.

Mr. Hartsog: I think the Judge said a few minutes ago that they could dissect that with regard to who the provider or insurance company was, and perhaps they could give that to the OIC to look at to see if there is a common thread or two or three. I think Dr. Becker at the February meeting mentioned. . .I think the term he used was "a few outliers" that were objecting.

Mr. Murdock: If you just sorted it out by percentage of reversals per carrier, that may give you a starting point. I think you would still have to look at each decision. If I'm a carrier where a good portion of my business may be covering one industry, or I may have a larger representation in one industry; whereas another carrier may have a large representation of their clientele in another industry, the whole universe of injuries that come from those two carriers are not going to coincide. So, just the fact that one carrier's decisions are reversed more often than another carrier's isn't going to give you a full story. I think you would have to still go through each decision and do an analysis of each decision to try to categorize it.

Judge Roush: I want to add. . .not to provide any kind of persuasive comment on the discussion. But just to say that the litigation universe is representative of those claimants who have chosen to take on a protest. We have no knowledge of the total number of claims filed at any given time. We don't know that information. There's no way to compare those claimants who have just said, "I'm going to choose not to appeal," or those who cannot even get counsel. Our universe of litigation statistics is really. . .unfortunately it just is what it is. And I don't know that you can use it in that sense to say that its representative of a fact that there's not. . .

Mr. Hartsog: Well I agree with you. I thought that that would be a starting point with regard to insurance companies or providers or whomever that are actually denying it as a starting point to see if in looking at the decisions or whatever to determine if there is one out there, or two out there or three out there that are actually denying.

Mr. Murdock: Sure. It is certainly a relevant indicator, and it may be something useful for us to take a look at. I would agree with that.

Ms. Pickens: We would. That's part of the market analysis and market conduct that we routinely do anyway because it's a tool and it's available to us. And I can certainly understand why everybody wants to understand the genesis of the rules or a need for the rule, and things of that nature. But we do want to point out that we do believe it's a standard around the country. There are a lot of insurance rules. There are a lot of workers' comp rules. Not all rules exist to address a specific problem, crisis,

dilemma, etc. Sometimes they're just measurable standards, and our experience with the insurance industry is that that they like measurable standards. They like knowing what the expectations are so that they can conform to them. I think it's notable that AIA – which is a large insurance trade organization that we've had a lot of contact with through this whole privatization process – had one comment to the rule which was the West Virginia licensed physician issue. As far as requiring "a physician to provide medical review," they did not find that alarming. As Dan said, we don't have the information we had hoped to have about what is specifically required in other states, and we're going to get that. But I spoke with Dr. Becker a few minutes ago and he has spoken with a person where it is their job to do medical review around the country – a national organization – and they do it in every state. She indicated that she can give us some specific information, which of course they have because they have to know what they're required to do. It's their job. She says it is extremely common. They do it in every state. Virtually every state has a legal requirement to perform when denials – if you're talking about some specific denial of a medical treatment issue – that it needs to be moved up to someone with medical expertise, which is what Commissioner Cline has said from day one. She wants to make sure that medical people make the medical decisions in claims.

Mr. Hartsog: Does a claimant get anything that describes to them what their rights are with regard to their right to protest; their right to protest it to the Office of Judges; if they have a grievance procedure internally? Is anything like that given to the claimant so they know what they can do? Because part of what he might be describing is a situation where they don't know that they can. They don't know what avenue is available to them.

Mr. Murdock: At the outset of a claim where there's a temporary total disability loss time claim, the claimant gets a brochure that describes generally the workers' compensation process – this is where you can contact your adjuster, things like that. With regard to the medical issues, there are certain elements that have to be included in that denial when it goes out that advises the claimant of his right to protest, and that is actually in that letter that he receives. Again, the claimant may have that notice. It could be a daunting process for certain people because they don't understand it. Or what happens is they say, "It's not worth the hassle. I'll put it on my wife's insurance." They find another payer or they give up.

Chairman Dean: Any other questions, Mr. Hartsog?

Mr. Hartsog: Yes, I have a couple more. Where it talks about treatment requests, in section 4.1, it says, "acknowledge, in writing, any treatment request within 15 working

days. . ." Then if I go back to 3.1 it talks about treatment request for surgery. Is treatment request in 4.1 defining any request for medical treatment, or are you specifically going back and saying "treatment request?" Are you just talking about surgery, medical devices – what you have under 3.1.a. and 3.1.c.

Mr. Murdock: That was a significant revision because the comment had been made, "what a treatment request constitutes." You see treatment requests that come in that are not from doctors. They're from the claimant's lawyer. So, in subsection 2.8 we specifically limit what a "treatment request" is, and that is. . .first of all the request has to be "made by the claimant's authorized treating physician or authorized consulting physician. . ." So the claimant can't go to his brother-in-law, the chiropractor, and have that guy submit a treatment request. It has to be from the "authorized treating physician or an authorized consulting physician." And we are going to put together a form, which is not uncommon. I've been looking at Ohio's form and I think our form will probably be based on the Ohio form. That form lets the carrier know that this is an actual treatment request. When they get that form they know they have to look to this rule. If they don't get that form they don't have to look to this rule. It clarifies exactly what a "treatment request" is going to be. Then when you go down to subsection 3.1.a. where it says, "a treatment request for surgery," what that essentially means is a treatment request on that form signed by the claimant's authorized treating physician requesting surgery. And if it doesn't fit that definition, it's not in this rule. If you go down to the "deemed approved" language, again, that's the same thing. It's a treatment request, and that treatment request would either be for surgery or durable medical equipment. And that request again has to be on the form signed by the claimant's authorized physician. If you don't have those prerequisites, then you don't have to do anything under this rule at all.

Mr. Hartsog: So is 4.1 supposed to be acknowledging a treatment request for 3.1.a., 3.1.b. and 3.1.c.?

Mr. Murdock: No. The only sections under three that are treatment requests are (a) and (b). So (c) and (d) are out. It only applies to those two situations.

Mr. Hartsog: So does 4.1 apply only to a treatment request for surgery and a treatment request for any durable medical equipment.

Mr. Murdock: That's right.

Mr. Hartsog: Only those two types of medical treatment requests need to be included in the acknowledgement in writing?

Mr. Murdock: Right.

Mr. Hartsog: Okay. It's not the way I read that. Thank you. Do you think or perhaps how do you feel about. . .I know that a person has the ability to request an expedited hearing [on a medical issue] which I think it can be done in less than 30 days or about 30 days, somewhere in that perimeter. Is an expedited request used very much?

Mr. Murdock: One of the Judges here might be able to answer this more specifically. I know that it hasn't been used. . .I think maybe it's being used a little more. But over the past several years since that's been available it is not used in a large percentage of treatment request denials. The reason for that. . .first of all it requires the claimant to opt into that expedited hearing process. A claimant has to request it. The claimant may not understand that step. And additionally, if the claimant sends in the information from his doctor; the doctor sends in all of his information and makes a request that's denied; he's put everything he has out there; it's been denied. If the claimant is going to expect to prevail at the Office of Judges, the claimant has to go there and then prove that he's entitled to this treatment which oftentimes will require him to get additional medical information. Once it goes into litigation that expedited process often doesn't give the claimant enough opportunity to get everything he needs together to be able to litigate that issue. It's available but it is not used.

Judge Roush: I want to point out that the expedited hearing statistics are on page 11 of the Industrial Council's report.

Mr. Hartsog: I need you to point out where I missed it.

Judge Roush: It's on page 11. In 2009 there were 90 expedited hearings. With regard to total treatment issues I think there were 1,300. The last time we broke these statistics down, which we probably should do for this report as well. There are three issues in which an expedited hearing can be held – on compensability, a medical treatment, and a temporary total disability issue. Almost all of these are compensability followed by a small number of medical treatment hearings. We might have had one PTD hearing. It is a rarely used process. To date for 2010, we've only had 21 expedited hearings.

Mr. Hartsog: Thank you. With regard to market conduct audits that the Insurance Commissioner has done and continues to do. Have their findings included cases where individual TPA's, insurance companies, etc. – have they found companies and if they

take an action against companies that have been unreasonably denying medical claims without having a substantive reason?

Mr. Murdock: If you look at the statute, the statute talks about unreasonable denial, and that statutory definition is very narrow. It basically talks about cases where essentially the Order on its face provides no rationale for the denial. If there is any sort of rationale offered, it's not unreasonable. With regard to market conduct, when our people go out there and look at these claims they'll see a denial and they'll look at whether the denial was timely made, whether the denial included the language advising the claimant that he had a right to protest. But there is really no standard available to that examiner when they go and look at a file to make a judgment as to whether the adjuster made the right medical decision. It would almost put that examiner in the same position where he would need to refer the file to a physician in order to know whether or not it was a good decision. So it's something that generally when we look at these denials, we're going to look at compliance with the statute, compliance with the regulations. That specific inquiry is something that would be very difficult for an examiner going in and looking at however many thousands of files the carrier has to make a determination as to whether the correct medical decision was made by the adjuster.

Mr. Hartsog: I would like some answers with regard to costs, looking at the denials, and some things along those lines. What I'm trying to get my arms around is more substantively, "what's the problem we're trying to fix?" I understand the best practice is to do something. But I don't want to create other problems. I'd prefer if that is going on to specifically address that, and if there is a better way to address the problems.

Chairman Dean: Mr. Dissen, do you have a question?

Mr. Dissen: I don't think this Council wants to do anything that would affect business development. And I'd be hard pressed I think to vote on a rule where you would say, "I don't know what it costs." That's a nonstarter for me. And assuming we do best practice because a lot of us in industry have done "best practice," I assume you use another state as a model you looked at. We have employers here who work in multi states and it may very well be. . .I say the devil is in the detail. Were there things added into this rule that other states didn't have that makes it problematic for some of our employers? I think we've got to sort that out.

Bill Kenny (Deputy Commissioner, OIC): I think our best measure for that – at least a measure we've used as we move this system into a competitive environment –

was a group of claims people that met from the industry itself that would meet on a regular basis and advise "what are the best practices that you the insurance carrier who is doing business in 46 states," and they would advise. The fact that AIA, which is their trade association, is in full agreement with this rule, tells me that we're not getting too far out and we are mirroring what they are most likely doing already. Claims adjusters have always told us that they've learned throughout the years that the most economical way for them to handle workers' comp injuries is to treat it medically, quickly and properly because it shortens the time and gets a better outcome for the injured worker. That better outcome also gets them a better outcome financially. You want somebody cured to the maximum degree possible and back to work. They've repeated that over and over to us, and that's one of the things we routinely do is consult with. . .

Mr. Dissen: Well, then they should be able to give you a model that's used in some other state.

Mr. Kenny: I don't know that other states necessarily have rules like this or not.

Ms. Pickens: My understanding is that it is very common to have legal requirements, and this is pure speculation on my part. I consider this rule to be actually very limited.

Mr. Murdock: It really is a very narrow. . .

Mr. Kenny: We can do some specific research for you.

Mr. Dissen: The only reason I raise more of an academic issue is that with the number of comments we received and the number of employers who have operations in different states may very well be that they have seen something in here that they don't have in other states and it's raising an issue. But the cost. . .you have to show some numbers. The practical impact is you want the medical review, and I've heard you say that over and over. It seems to me that employees and employers in managed care plans have this medical review already and they are paying a premium on it. So why would they be paying a premium again if this rule is passed? I mean it seems to me that if you're going to do that, then under Section 5 under the exemptions, any employee or employer that's in a managed care plan should be exempted from this rule.

Mr. Murdock: I'm not sure I follow you one hundred percent what you're saying.

Mr. Dissen: BrickStreet goes back and they have this medical review.

Mr. Murdock: If they are already in compliance with the rule, then I don't understand whether they are included or excluded.

Mr. Dissen: Managed care plans were developed to reduce medical costs. Companies jumped on it. There may be some that didn't. Technically, I mean depending on how this rule finally comes out – as I say the devil is in the detail – you could have companies paying a premium under managed care and then get hit saying, "By the way you're going to have to have another doctor review some other issue." That's a double dip.

Ms. Pickens: I think we did get comments on Rule 21 and how it would mesh with the grievance process. Again, this rule is very limited. A grievance process I assume is going to apply to any medical treatment. This doesn't replace it. This is a front end doctor review with regard to very limited types of treatment requests and prescription requests.

Mr. Murdock: This rule would apply to a denial.

Mr. Dissen: Let me ask you this. Have you looked at the managed care plan impact on this rule?

Mr. Murdock: No. I don't think. . .

Mr. Dissen: Well, I think you ought to look at.

Ms. Pickens: We've considered it and discussed it, and we think it's entirely separate and it shouldn't have an impact on it.

Mr. Murdock: To work through it, for example, BrickStreet has a claimant and that claimant's doctor requests surgery and the adjuster looks at that. My understanding is that at BrickStreet medical denials are not made at the adjuster level; that there is already some kind of review in place. I don't want to speak for them but that's my understanding. But say. . .we won't use BrickStreet. We'll use "Hypothetical Insurance Company." The claim comes in. When they send out that first denial or that first letter saying, "We're not going to approve this treatment," that's not a decision denying that treatment. It's interlocutory because the claimant still has an opportunity then to pursue the grievance process. So as a technical matter, when they make that first determination – and I don't know why someone would do it this way – but if they did make that determination. . .the denial that has to conform in this rule is the final denial that goes out that says, "Your request has been denied. You have 60 days to protest

this decision at the Office of Judges." The grievance process would occur before this rule would be effective. This rule concerns that final denial that goes out. If you have a claimant that makes a protest; it goes into the grievance process; the doctor at Hypothetical Insurance Company finally looks at it and he says, "Yes, I agree. This should have been denied." You have your review then for the purposes of this rule. The doctor has looked at it. That whole grievance process is occurring. It's preliminary to the final letter that goes out denying – the protestable decision that goes out denying the treatment.

Mr. Hartsog: On a medical group plan like that, it's filed and approved by the Insurance Commissioner before it's put into place as I understand it. And if it's filed and it's put into place it has a process in it that's approved by the Insurance Commissioner. A lot of those plans have grievance procedures that can go through internally. I don't mean to put words in Jim's mouth, but what part is part of what's in this rule. . .I would assume supersede whatever is in those managed care plans that are already. . .

Mr. Kenny: Let's not confuse managed health care plans with workers' comp law – two different issues. But if you want to use it as an analogy, I think what Dan is saying is you don't get to the stage of final denial until you've gone through those grievances. And in that grievance process – and I know that most do it, there could be some exceptions – there is a medical review. You've already satisfied this rule, right. So it shouldn't have any affect on managed care plans because they are already essentially doing this. They're just doing it before the final denial. To get to the final denial they've already done it.

Mr. Hartsog: There is a managed care plan that's part of workers' comp. . .

Mr. Kenny: Could be. You could have a network, yes. . .

Mr. Hartsog: . . .that has a network that's approved and that process is approved currently by the Insurance Commissioner because they all have to go through and get okayed. Then if that managed care plan has been. . .and then a company has a process to find in there where an adjuster looks at a claim; makes a determination; provides the claimant that determination so that that piece can get done quickly; it comes back and they decide to use the grievance procedure but then goes to a medical doctor at that point; and then the medical doctor considers it; this rule would in essence preempt that procedure that they already have in place, correct?

Mr. Murdock: No.

Mr. Kenny: This doesn't take effect until the final denial, and that's all prior to the final denial. All of that has occurred prior to the final denial. We don't approve managed care. . .

Mr. Sims: We approve it for comp carriers.

Mr. Murdock: If you had a managed care plan and it was submitted to us and it entailed – and I don't routinely look at these plans; I'm just speaking generally – but if that plan called for a request for surgery to be reviewed by a registered nurse rather than a physician, then this rule after that grievance process, would impose an additional requirement in the limited circumstances addressed in this rule.

Mr. Hartsog: You answered my question. That's what it would do and that's where this rule would supersede what's already been filed and approved by the Commissioner.

Mr. Murdock: No. I don't know that it supersedes it. I think it's an additional requirement. That plan that they have submitted. . .

Mr. Hartsog: That requirement would supersede what's in the managed care plan right now, correct?

Mr. Murdock: No.

Mr. Kenny: The managed care plan can still work, and quite often resolves the issue before it ever gets here.

Mr. Hartsog: You may have a. . .requirement. . .

Mr. Kenny: Only after they've gone through all of that. So it doesn't supersede it. And quite often that process is resolving. . .it doesn't supersede it. It allows that process to occur. If it resolves the issue, it resolves the issue, and quite often it does. What Dan is proposing here is after you get beyond that "now it's denied." What can the injured worker do to make sure that the decision is correct?

Mr. Hartsog: In the example he gave us. . .if the claim comes in and a registered nurse looks at it and she says "no" and denies it. The claimant gets it back. At the point when this rule is implemented, she couldn't deny it. It would have to go to an M.D. and get denied.

Mr. Sims: Within the managed healthcare plan structure?

Mr. Hartsog: Yes.

Mr. Sims: No, I believe that's separate. You could deny it within the structure of the grievance in the managed healthcare plan. Go through that process and then if after that it is arbitrated through that process. . .

Mr. Dissen: What if it wasn't a registered nurse? What if it was a medical doctor?

Mr. Murdock: Then you've complied with it.

Mr. Dissen: So if a person had a managed care program and they had the things reviewed by a medical doctor which they're paying for, then they would be exempted from this rule.

Mr. Kenny: They would be in compliance. That's all the rule is requiring them to do.

Mr. Dissen: What's the difference between being in compliance and being exempted from the rule?

Mr. Murdock: The rule would still require them [in the limited situations that are set forth in here] to have it reviewed by a doctor. But if it goes through their grievance process and their doctor looks at and he says, "Yes it should be denied," then they've met the definition of "medical review." They've had a licensed physician look at it and the denial is based on the opinion of that licensed physician. So they've complied with the rule. They have to do that. And the way that they are set up ensures that they will in those circumstances, but they still have to comply. They are not exempt. The rule can still apply to them. If they got their request in and they didn't acknowledge it within the timeframe, the rule would apply. If they issue a decision and they leave out the name of the doctor on which his opinion is based, they would not be in compliance with the rule. They would still have to do those things.

Mr. Dissen: You may need some kind of clarification. This is going to be confusing.

Mr. Hartsog: Bill, could you help me out again on what we were just talking about? I have a managed care plan in place, okay. Right now that plan calls for a nurse to do the initial review, checking of it, and then she denies a claim in that instance. Then the claimant gets it. They obviously disagree. They grieve it through normal procedure

that's in my plan. It goes to an M.D. The M.D. looks at it and they decide "okay, fine" or they decide against it too, and then the claimant has alternative ways to go about pursuing it. Now in that situation it would seem to me if this rule will pass as it is right now that that registered nurse could no longer deny the claim and go back to the claimant that it would have to be an M.D. that would review the claim.

Mr. Sims: I think a nurse could deny it under the approved managed healthcare plan and say you have a redress by appealing within this structure of this managed health care plan. That would be outside the scope of this rule.

Mr. Murdock: Absolutely.

Mr. Sims: You go through the process. . .and like you said, then it goes to a doctor as part of that utilization review, if that's in their plan.

Mr. Hartsog: Should we come back and add an exemption for an MCO to this and make it clear that those plans are exempted from this rule?

Mr. Kenny: I don't think you would want to exempt them from the rule. I think you want to make it very clear that they have complied with the rule.

Mr. Sims: Because the final result after that whole process is done is an exemption from that rule. If the claimant goes through that whole managed health care process, gets his arbitration or utilization review and the decision of the plan is still denied, then you would have to issue him a decision. After going through this grievance process and it's still denied, then he would have an objection to the Office of Judges and that would have to be applied to the process. The rule would apply to that.

Mr. Hartsog: If it's addressed in here, it went way over my head.

Ms. Pickens: I think this is an interesting issue and that perhaps we could bring more clarity to it. We need to think about that.

Mr. Sims: I think you could put language in here to address this.

Mr. Hartsog: When I read this rule obviously those kind of things popped in my head. And reading it I don't think anyone would pick up that. . .well, if you have a managed care plan, you can follow that whole process. It's not until it goes through the grievance process and everything that it's okay.

Chairman Dean: Mr. Dissen, do you have any other questions?

Mr. Dissen: No.

Chairman Dean: Mr. Chambers, do you have any questions?

Mr. Chambers: Yes. First, I want to clarify something that was an earlier question or maybe I just misheard. Did you say that 4.1 only applies to medical requests for surgery? I thought I heard you say that.

Mr. Murdock: Yes. Let me just run you through it real quick. If you go down to the third line of that paragraph, you see that term "treatment request?"

Mr. Chambers: Yes.

Mr. Murdock: That's a defined term by the rule.

Mr. Chambers: And it's defined in 2.8, but the definition in 2.8 doesn't restrict it to a request for surgery. It's in 3.1, but that's a different subject. I don't see where the language is that restricts 4.1 to "medical requests" for surgery.

Mr. Hartsog: Well, do you understand my confusion?

Ms. Pickens: This I really do think is technical. I think 2.8 – if that is confusing people – it could be changed to clarify that you're not talking about "any treatment" in the world. You are talking about "certain treatments" which are then defined in 3.1.

Mr. Chambers: Because 3.1 does restrict them, but 4.1 doesn't. I don't see the language where it does because the 2.8 definition is broader than the 3.1.

Mr. Kenny: The solution is to tighten up 2.8 to make sure that it is very clear.

Mr. Marshall: A cross reference. . .

Mr. Chambers: It could easily be fixed.

Mr. Sims: I think you could almost narrow 2.8 to just say, "It only applies to requests for surgery or durable medical. . ."

Mr. Marshall: That would be helpful.

Mr. Chambers: With regard to how many other states have a medical review, that matters to me and I hope that we have those numbers. But can we make sure that we are very specific on how many states have a medical review by a physician. I've heard in many cases that a medical review is done by a nurse. So I want to make sure if we are saying other states have this rule that it is "medical review by a physician" as opposed to medical review by a nurse or somebody else.

Ms. Pickens: We ought to be able to get that.

Mr. Chambers: In reading some of the other materials from the public hearing, somebody made the comment – maybe it was Mr. Sims – that we think any carrier that already uses URAC or some other established certification would generally meet this rule, and that many insurers adopt these standards. Can we quantify that? How many insurers that are operating in our state are already using URAC? And is that review, again, a physician as opposed to just some medical person?

Mr. Pickens: If Dr. Becker were here he could certainly talk to you about the URAC standards. I don't know if we're going to know exactly. We can tell what's in state law and rules, but as far as what internal procedures. . .I mean URAC standards are very common.

Mr. Kenny: I don't know if we can get them exact, but I think we can at least get them anecdotally from the trade associations. They can survey their members to the extent they will get a response.

Mr. Chambers: That would be helpful, but certainly if we could quantify what states, to me that's significant. With regard to the cost of this, we will have information about that before we have to vote on this?

Mr. Kenny: Yes. It's in the works right now actually.

Mr. Chambers: I have a couple of questions about the last part of this, and that is the notification requirement. My understanding from reading materials from past meetings, the issues that were cited that are the reasons for that rule are: too many claimants don't know or can't find out where their claim stands; where decisions have been made; and what those decisions are. And I guess I don't understand how just having an acknowledgement that there has been a request addresses that problem. That sounds like a problem that needs to be addressed. But how does just an acknowledgement help that? And did you give any consideration to. . .as I understand

Rule 1, you've got 15 working days to make a decision. I gather that doesn't always happen that way. But did you give thought to tagging this notification to that, to notify after 15 working days what that decision was as opposed to just an acknowledgement that we got the request?

Mr. Murdock: With regard to the decision. . .with the things we're talking about here, if somebody needs surgery, for example, that's usually a more complicated claim than a claim where somebody is requesting to go to the chiropractor for a couple of weeks. It's a more expensive procedure if somebody is requesting a $40,000.00 back surgery or they are getting surgery for a knee replacement. Those are very expensive surgeries. So we don't want to force anybody to make a decision in 15 days. Rule 1 requires them to act on that. That means that they have to start taking affirmative steps towards resolving it. We can't expect a carrier in all instances to make that decision in 15 days. A lot of them do on almost all issues. The turnaround can be pretty good.

With regard to the acknowledgement question, one of the issues that we get very, very often through our Consumer Services Department is: The claimant goes to the doctor. The doctor says, "I'm going to request this for you." The claimant goes home and the claimant doesn't know whether the doctor submitted the request. The claimant will call to try to get hold of their adjuster. These adjusters are, for the most part, very hard working people but they also manage a lot of claims. We get complaints that the adjuster is not returning my calls. So you have the claimant; his doctor says he needs this treatment. The claimant is obviously feeling some type of symptom where he agrees that he needs some type of treatment, and the request is apparently out there, but the claimant doesn't even know if anybody is looking at it. We feel that it is important for the claimant to know that the request has been received. It is important for the carrier when they receive that request – again in a limited number of circumstances – to tell that claimant, "Yes, your doctor did in fact request the surgery. We're looking at it; or we made a decision." We feel that's important.

There are a lot of provisions in insurance law generally in West Virginia and around the country that does require some type of response, and 15 days is a typical number. And we don't think it's unreasonable at all that that communication occurs. We think that it is a reasonable requirement to impose on the company and that's why it's in there.

Mr. Chambers: I can see where this would help the claimant know whether the physician did his job. But I still struggle to see how it helps claimants know where their claim stands and whether the carrier has made a decision and so forth. With regard to

that, will we have information on what this will cost? Is somebody working on what the cost of this would be?

Mr. Pickens: That would part of the NCCI analysis.

Mr. Chambers: Will you look at how many other states have this rule and tell us specifically how many other states require an acknowledgement?

Ms. Pickens: We can.

Mr. Chambers: I need to re-think it in terms of its limitation now that it's just a request for surgery. So that probably makes a little difference in how we see that, but it would be helpful to know that as well.

Chairman Dean: Anything else, Mr. Chambers?

Mr. Chambers: That's all I have for now. Thank you.

Chairman Dean: Very good. Delegate Guthrie, do you have any questions?

Delegate Nancy Guthrie: Just a point of clarification if you will. The folks who are in the Old Fund, do they have the same access to the grievance process as the folks that are not in the Old Fund?

Mr. Murdock: No.

Delegate Guthrie: So there is no redress.

Ms. Pickens: There is no managed care network for the Old Fund.

Mr. Murdock: There is no grievance process in the Old Fund. Part of the grievance process is under a managed care plan where the company can go out and select the physicians they want you to go to. Under the Old Fund the claimant can go to any physician that they choose. So there is no managed care plan in place for the Old Fund. But the grievance process is not a universal process that's available to anybody who is covered by a private carrier. It's only those carriers that put in the managed care plan.

Delegate Guthrie: Then I guess the next question would be – are you receiving complaints from claimants that the carriers that they have been referred to or who are

now handling their claims are in essence doctor shopping until they can find a doctor that will deny a claim? Are you getting many of those?

Mr. Murdock: We have seen some complaints about certain physicians. As a general matter. . .

Delegate Guthrie: It's not the physicians I'm speaking of so much as I am the insurance carriers.

Mr. Murdock: That's a good question.

Delegate Guthrie: Can you get statistics on that? I would like to know. From the Old Fund only, how many complaints of that nature are you receiving, and whether or not there is a pattern on which insurance carriers are. . .

Mr. Murdock: There are no other insurance carriers involved with the Old Fund. The Old Fund is. . .

Delegate Guthrie: Well there are adjusters, right? Claims adjusters?

Mr. Murdock: We have three different TPA's that we use.

Delegate Guthrie: I would like to know if there are any of them that seem to be denying more claims than others.

Mr. Murdock: We could get you that information.

Mr. Kenny: I don't think it's going to tell you what I think you're trying to get. We have three TPA's. One of them handles the majority of the injury claims. In fact, essentially all of them, unless that claimant also has either a black lung claim or a state OP claim. One of the other carriers does all the black lung, and one of the other TPA's does all of the state OP. We didn't break the claims up equally among three TPA's. We broke them up kind of a specialty. So the difference then is Sedgwick, the largest one, has right at 20,000 open claims right now. Wells Fargo and American Mining, who do state OP and federal black lung, and any affiliated claim. If that person also happens to have an injury claim, we didn't want that injured worker to have to figure out which TPA to go to for which issue. We want to treat the whole body, so we package all the claims up with the black lung claim or the OP claim. They each have somewhat less than 4,000 claims. Because they are dealing basically with different situations, the number

of denials would not be comparable, even on a percentage basis because it's a different type of claim. We don't get a lot of those complaints anymore.

Delegate Guthrie: I do.

Mr. Kenny: Not that we don't get any. We don't get much anymore. Remember that we use an open system where the claimant chooses the physician. We don't pick the physician, so that mitigates a lot of that. We have a very formal auditing program that we do on our TPA's twice a year, and it's rather complex but I think a very thorough audit. So we can pick up any of those if we see any outliers. And we are now on the third round of audits and I just received a preliminary on one the other day. They are all getting much, much better than they were because of our system. These are old claims. They are not brand new injuries and it is difficult. We do watch that anecdotally. We'll look at our claims basis. I'm not seeing nearly, nearly what we were.

Delegate Guthrie: I would like to see the numbers just out of curiosity.

Mr. Kenny: Yes, we can look and see.

Delegate Guthrie: Because I think one of the concerns by claimants is having this new privatized system. They are used to a report from their doctor that says. . .these are the things that they are going to need probably for the rest of their lives. And all of a sudden a carrier comes in and says, "You know, we think you should see our doctor." And then all of a sudden everything that the claimant has been using for 30, 40, 50 years, at this point they are being denied because the doctor that works for the carrier is denying their claim.

Mr. Kenny: Not in the Old Fund. We don't have any doctors working for us other than our medical director, of course. But he doesn't do any examinations. If there is an insurance carrier doing it, it is new claims, not the old ones.

Delegate Guthrie: These are old claims.

Mr. Kenny: There is no carrier. . .the TPA could send them out for an independent medical examination. That might be what that is. And we also have in the past looked at those to see if there is any particular physician that may be too conservative. We look at that very closely to make sure we get a fair assessment. We have found disruption from the claimant's side in the beginning because the old system frankly was rather liberal and not as controlled and there was some treatment going on that was not truly related to the injury. There were some prescriptions being prescribed that were not

related to the injury, and we put a process in place of weaning and tapering so that we didn't take anybody off [prescriptions] of it cold. But they had to get back to what was truly compensable. There are all kinds of stories out there. We can tell you of people who managed to have three different narcotic prescriptions that medically I'm told could not be and they could not be taking them all. There was some disruption from that standpoint, but it was done very, very gradually. In fact I know we still have some claims in there where we are treating some things that it could be arguably not related to the injury, but they have been treating that way for 15 years. You've got a 75 year old person, you can't do it. So we've allowed those in there. It's ones that are truly way out. I mean we found prescriptions for Viagra in workers' comp. There is no reason for that. You might be hearing some of those things perhaps.

Delegate Guthrie: No, not specifically. I understand what you are talking about, and that's a concern particularly in the southern part of the state. But I also know that there are instances where folks have been receiving treatment and their reports go forward. And now all of a sudden the adjuster says, "We want to send you to. . ."

Mr. Kenny: IME, independent medical examination. And truly if you get any of those specifically. . .we get calls from fellow members and others that are concerned. We can always have Dr. Becker look at them totally independent to see if there is something wrong there, and do that. We are happy to do that. If you get them, call me or the Commissioner and we will certainly deal with the specifics.

Delegate Guthrie: If we could get just a general snapshot. . .

Mr. Kenny: We'll see what we can find on that.

Ms. Pickens: Are you talking about complaints data?

Mr. Kenny: Yes.

Delegate Guthrie: Mostly. . .just the Old Fund.

Ms. Pickens: Maybe we should call you later and talk about it because I'm not sure honestly from the conversation if I exactly understand what we're looking for.

Mr. Kenny: IME's I think is what it amounts to. . .where an IME that could change the treatment protocol.

Delegate Guthrie: . . .(inaudible). . . understands what I asked initially. . .

Mr. Murdock: After the meeting maybe I can catch up with you and we can talk about it.

Chairman Dean: Very good. Thank you, Dan.

5. Update on Safety Study – Ryan Sims

Ryan Sims (Associate Counsel, OIC): We are in the process of collecting data. The official due date for it is May 1. A member of our staff in the Self-Insured Unit [who is also our safety in-house expert], prepared a report this morning for me. Of the top ten insurers, we received four surveys back so far. We are waiting for six. Out of the 49 self-insured employers that are not represented by a TPA, we received 32 of those 49 back and we are awaiting 17 surveys. Of the 49 self-insured employers that are TPA represented we received 17 and we are waiting for 32. We suspect that there is probably a coordinated effort. A lot of them use the same TPA's. The deadline is May 1. We think there will be some late data that comes. Michael Nowlin has been very diligent about calling them and reminding them that the date is coming up. But if the deadline passes we are going to accelerate a call and remind them that they have a duty to give us this information.

We wanted to suggest to you since the timing of the June meeting is June 3 we are proposing. . .you [Industrial Council] have the ability to have a special meeting, and it's under Section 4.1 of the Procedural Rule. And I think in this instance, because we will be getting the data in May, June 3 would be a little quick for us to get you a semi-final report that you can tweak. The rule requires three people to recommend a special meeting and the Chairman to ask for it. And if that occurs, we can go ahead and work on scheduling a special meeting in mid June to discuss the Safety Report specifically.

Ms. Pickens: If that's the will of the Committee our staff will schedule it.

Mr. Sims: I don't think you have to do a motion, but if three people. . .

Mr. Marshall: If it's appropriate to do that, do we take that action now at this meeting?

Mr. Sims: Yes.

Ms. Pickens: Actually I think the Chair can call it at his discretion. If three people say we want it, then the Chair has no choice and he must call it.

Chairman Dean: Are there three people on the Council that would like to have a special meeting? It's unanimous. We would like to have a special meeting. Can you schedule it?

Ms. Pickens: We'll take care of the proper notice and those kinds of things.

Chairman Dean: Very good. Anything else, Ryan?

Mr. Sims: Just to let you know that we are collecting the data and we will have a report for you. And of course we would get that semi-final draft out to you well before the meeting.

6. Legislative Update – Mary Jane Pickens

Mary Jane Pickens (General Counsel, OIC): I'll try to make this brief. I apologize to Mr. Chambers, our newest member. I neglected to introduce him at the beginning of the meeting. Everyone here has probably met him and already knows him. But I just wanted to say a few words. This is Mr. Chamber's first meeting. He is an Equity Director and member of the Leadership Committee for Brown Edwards & Company L.L.C.. Chambers, Paterno & Associates, where you were the managing partner for many, many years here in Charleston, merged into Brown Edwards & Company fairly recently, right?

Mr. Chambers: November of 2008.

Ms. Pickens: Mr. Chambers has over 30 years of experience in assisting small business clients here in our state in a number of different areas and working with them on a wide range of things, including strategic planning, analysis of business models, assistance with business reengineering initiatives, and estate planning related projects. Mr. Chambers graduated with honors from The Ohio State University with a Bachelor of Science Degree in Business, concentrating in Accounting, and is a member of the American Institute of Certified Public Accountants and the West Virginia Society of Certified Public Accountants, and a former Chairman of the Boards of Directors of the Charleston Chamber of Commerce and the Business and Industrial Development Corporation (BIDCO). Welcome to our Industrial Council.

Mr. Chambers: Thank you. So far I am glad to be here.

Ms. Pickens: Again, I'll keep this brief and the Legislative Session enables me to keep it brief. There were only four bills that had any real relationship to workers' comp during the past 2010 Session.

HB 4155 – Permitting revenues allocated to volunteer and part-time fire departments to be used for workers' compensation premiums. This is a bill that actually amended nothing in 23, nothing in 33, but Chapter 8, which relates generally to the expenditure of revenues from the Fire Protection Fund for the benefit of volunteer and part-time volunteer fire companies. It added some types of things for which expenditures from that fund could be made. And one of the things that it added or authorized was the expenditure of funds from that account for workers' comp premiums for those volunteer and part-time volunteer fire companies. The Insurance Commissioner for a long, long time has collected premium tax from insurance companies, pursuant to various Chapter 33 Code Sections, and then the Insurance Commissioner transfers money to those funds. This is also the bill, as it was introduced, that had the Length of Service Awards Program language in it and would have involved the Insurance Commissioner in that program. But those words were removed from the bill before it passed.

HB 4273 – Providing enforcement remedies and penalties against unlicensed Professional Employer Organizations operating in West Virginia. This was on the Insurance Commissioner's legislative agenda. It was really cleanup from prior legislation relating to Professional Employer Organizations or PEO's operating in West Virginia. When the Legislature initially passed that body of law a year or two ago it had some remedies that the Insurance Commissioner could pursue against a licensed PEO, but neglected to mention what happened if there was an unlicensed PEO operating out there. So this went back and cleaned that up and gave the Insurance Commissioner enforcement authority, and also specifically enabled the Insurance Commissioner's Fraud Unit to investigate fraud as it relates to suspected violations of the PEO Act.

HB 4459 – Increasing the time within which dependents may apply for workers' compensation death benefits where occupational pneumoconiosis is determined to be a cause of death. This is a bill that increased the time within which dependents may apply for workers' comp death benefits where OP is determined to be a cause of death. It amended W. Va. Code Section 23-4-15, but only in subsection (b). It increased the period of time for dependents to apply for death benefits in the event of an OP related death from one year to two years from the employee's death. The statutes of limitation on death benefit claims resulting from the injuries or other

occupational diseases wasn't changed. It makes it a little tricky when you add in the new notice that the Insurance Commissioner is required to create, which we are working on as we speak. Under W. Va. Code Section 23-4-10, a new subsection (f) was added which requires the Insurance Commissioner to create a form notice to be sent to the dependent by the administrator of any claim for 104 weeks benefits to notify them at the beginning that they've got the ability perhaps to qualify for death benefits. And then six months before the end of the 104 week benefit, the same type of reminder so that those people are kept aware of their rights and they don't "not" to do something because they just didn't know.

HB 4615 – Authorizing political subdivisions to establish risk pools to insure their workers' compensation risks. A number of years ago the Legislature authorized political subdivisions to establish risk pools for other types of liability claims, but not workers' comp because back when the Legislature did that you had the state system to take care of your workers' comp. But this will enable those political subdivisions that have established those risk pools for general liability types of claims to add workers' comp to that. This is going to require a rule. We have an existing Title 114 insurance rule on these liability pools, and we are going to have to amend that to incorporate this new capability to work workers' comp in.

Chairman Dean: Are there any questions?

7. General Public Comments

Chairman Dean: Does anybody from the general public have a comment today?

8. Old Business

Chairman Dean: Does anybody have anything under old business from the Industrial Council?

Mr. Hartsog: Just one question. What's the intent with regard to bringing the Return-to-Work rule back?

Ms. Pickens: The intent is to bring it back. I think we were hoping in May, but it depends on how much time we have to re-visit that and work on it. Dan will probably work on that one too.

Chairman Dean: Is there anything else to bring up under old business?

9. New Business

Chairman Dean: Does anybody from the Industrial Council have anything under new business?

Mr. Hartsog: Can we get something on the agenda either next time or the time after with regard to updating us on the status of the Old Fund?

Ms. Pickens: Sure.

Mr. Kenny: What do you want to know – financials, the number of claims, etc.? I can send it to you right now. We do it every month for the Joint Committee. I can send you that report.

Mr. Hartsog: That's fine.

Chairman Dean: Anything else under new business?

10. Next Meeting

Chairman Dean: The next meeting is Thursday, June 3, 2010, at 3:00 p.m. Does that meet with everyone's schedule?

11. Adjourn

Chairman Dean: I'll entertain a motion for adjournment.

Mr. Dissen made the motion to adjourn. The motion was seconded by Mr. Marshall and passed unanimously.

There being no further business the meeting adjourned at 4:57 p.m.